NH Bureau of Developmental Services
Request for Waiver to He-M 1201

Responsible Area Agency (circle): 1 2 3 4 5 6 7 8 9 10 11 12 **Date:** _____

Request is for an **Initial** ☐ or **Renewal** ☐ waiver?

Provider agency name and address (if applicable):

Residence or Day Service name and address:

Indicate specific section of **He-M 1201** for which a waiver is being sought: **He-M 1201**._____.

_____

_____

Provide an explanation of why a waiver to this standard is sought:

_____

_____

_____

_____

What alternative is proposed to satisfy regulatory intent?:

_____

_____

_____

_____

_____

Number of staff/providers authorized to administer medications: _____Nurse Trainer phone #_____

Number of people receiving medication within certified service: _____

I certify that policies and procedures are in place for:

- Nurse Trainer oversight of authorized staff
- Communication protocols between Day and Residential Services

Nurse Trainer signature:_____Date:_____

Individual/Guardian signature (if applicable):_____Date:_____

AA Executive Director or designee signature _____Date:_____

Medication Committee: Approve ☐ Deny ☐

Medication Committee Chair signature:_____Date:_____

Submit completed request to:
BDS
ATTN: Medication Committee
State Office Park South
105 Pleasant Street, Main Bldg
Concord, NH 03301